2011 - 2012 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ _____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ _____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Site (Circle)	Route (Circle)	Date On VIS	Date VIS given
	TIV LAIV				Yes No	Yes No	Intranasal Intramuscular Intradermal	R Arm L Arm R Leg L Leg	7/26/11	
	PPV23				Yes No	N/A	Intramuscular Subcutaneous	R Arm L Arm R Leg L Leg		

Clinic Site Name: Newton Health & Human Services Department MDPH Provider PIN#: _____

Clinic Address: 1294 Centre St. Newton, MA 02459

Signature of Vaccine Administrator: _____ Date: _____